FOREWORD

The format of the Peoria Area EMS System (PAEMS System) Prehospital care manuals has changed several times throughout the history of the System. The initial protocol manual (June 1983) consisted of ALS field treatment protocols. Changes in IDPH rules and regulations resulted in the addition of ILS protocols (July 1990), BLS protocols (November 1992) and First Responder protocols (April 1998). In 1994 the PAEMS System Policy Manual was developed to address medical-legal issues and concerns and, in 1995, procedures were formatted into a Standard Operating Procedure Manual.

With the complexity of a tiered response system and with the growing demand that health care services are both effective and efficient, the format for providing medical direction and patient care guidelines changed again in 2002. The separate manuals outlining field treatment guidelines, policies and procedures were all combined into one manual, the *Prehospital Care Manual*. This manual has become the focal point for patient care for Peoria Area EMS System providers in the Prehospital setting.

This 2020 edition has dramatic changes made to the protocols to reflect changing national evidence-based trends in an effort to provide optimal patient care.

All information contained herein is intended for use within the Peoria Area EMS System. No other system's protocols, policies, or procedures shall supersede the guidelines set forth in this manual or be utilized in place of this manual by a provider in the Peoria Area EMS System without the approval of the Peoria Area EMS System Medical Director.

From the EMS Medical Director

The mission of the Peoria Area EMS System is to deliver the highest quality health care that can be achieved with available resources. A uniform application of the protocols will ensure that competent and efficient care is provided to our patients. Our mission is accomplished by pursuing the goals of providing strong prehospital education and training. The protocols will help resolve potential problems that may jeopardize the health and safety of the patient, prehospital healthcare provider or the community.

As your EMS Medical Director, I welcome your input and encourage your suggestions by promoting an "open door" atmosphere. The EMS Office is a resource to assist you in accomplishing the mission of providing emergency medical services to your community. Please do not hesitate to contact us if we may be of any assistance to you or your agency.

It is my sincere wish that your experience with and service to the Peoria Area EMS System is both enjoyable and rewarding for you.

Respectfully,
Matt Jackson, MD
EMS Medical Director
Peoria Area EMS System

Glossary of terms that may help your understanding of specific protocols

Stable Patient-A patient is considered stable if they are alert & oriented, with pink warm & dry skin, present peripheral pulses, and adequate respirations.
Unstable Patient-A patient is considered unstable if they have one or more of the above criteria lacking, severe chest pain or discomfort, or altered level of consciousness, with signs or symptoms of hypo perfusion.
AHA Guidelines-Current recommended policies and/or procedures from American Heart Assoc. for BLS, ACLS, and/or PALS. PAEMS does not authorize the use of all AHA recommended medications. Check medication list for specific available medications.
ALS-Advanced Life Support level of care typically at the Paramedic and PHRN levels
BIAD-Blind Insertion Airway Device which PAEMS authorizes the use of an Igel
BLS-Basic Life Support level of care typically at the EMT or EMT-B level
BSI/ PPE-Standard on every call- non latex gloves, eye protection, surgical mask. Additionally gowns, face protection, N95's, head and feet protection, based upon patient presentation. It is required that there be a minimum of 2 sets per provider per call. Each agency should perform a N95 fit test yearly or whenever a provider requires.
Cushing's Response-A sign of increasing ICP (Intra Cranial Pressure)-decreasing pulse rate, increasing BP, and irregular or abnormal respirations
The Department-An abbreviated way of referencing IDPH
EMS Act-(515) http://www.ilga.gov/commission/jcar/admincode/077/07700515sections.html
EMS Provider-Any provider at any level from EMR-EMT-I-P-PHRN
Extravasation: An infiltration or leaking from an IV/IO site into the extravascular tissues
ILS-Intermediate Life Support level of care typically at the EMT-I or Intermediate level
Medications-Medications authorized by PAEMS protocols from the date of protocol introduction. This is subject to change based upon med availability along with policy and protocol changes.
Policy-A defined rule or regulation of the system
Procedure-A step by step direction to perform a specific task
Shock-Signs or symptoms of hypo perfusion are present in your patient.
SMO-Standing Medical Order from the Medical Director-no online contact necessary
SOP-Standard Operating Procedure
System-An abbreviated way of saying Peoria Area EMS System
Trauma Guidelines-Current recommended policies and/or procedures from ITLS and/ or PHTLS.
TWIAGE-A secure HIPAA compliant app that can be downloaded on any device to communicate with local ED's. See your agency for access.
Volume and Mass abbreviations:

mcg	mg	ml	mEq	kg	l	g
Microgram	Milligram	Milliliter	Millequivalent	kilogram	Liter	Gram

Peoria Area EMS Policy Section

Table of Contents

Click any heading below to jump to each respective section

FOREWORD 1
Table of Contents 3
Levels of Prehospital Care 5
Agency Responsibilities 6
Professional Conduct and Agency Code of Ethics 7
Agency Compliance Waiver/ HIPAA 8
Communications and Patient Care Report Policy 9
System Certification/ Relicensure Policy 11
Patient Right of Refusal and Destination Policy 14
Transfer of Care Policy 16
Intercept/ In Field Service Level Upgrade Policy 17
Incident Reporting Policy 18
Termination of Resuscitation (DNR) Policy 19
Withholding Resuscitation/ Notification of the Coroner/ Crime Scene Policy 21
Petitioning an Emotionally Disturbed Patient/ Physical and Chemical Restraints Policy and Procedure 23
On Scene Intervening Physician or other Medical Professional Policy 25
Concealed Weapons Policy 26
Infectious Disease Exposure Policy 27
Substance Abuse Policy 29
ALS Controlled Substances Policy 31
Medical Disaster and System Wide Crisis Policy 34
Suspected Human Trafficking Policy 35
Domestic and Elder Abuse Policy 36
Rape/ Sexual Assault Policy 37
Critical Incident Stress Management Policy 38
Region 2 School Bus Accident Policy 39
12 Lead Policy 41

Resource Hospital

OSF Saint Francis Medical Center
530 Northeast Glen Oak Avenue
Peoria, Illinois 61637
MEDCOM 309-655-2564
Medical Control 309-655-6770
Emergency Department 309-655-2109
Regional Service 800-252-5433

Comprehensive Medical Center
EMS Medical Control
Level 1 Trauma Center
Pediatric Hospital
Disaster Medical Services RMERT

Participating Hospitals

UnityPoint Health – Methodist
221 Northeast Glen Oak Avenue
Peoria, Illinois 61636
Medical Center 309-672-5522
Emergency Department 309-672-5500

UnityPoint Health – Proctor
5409 North Knoxville Avenue
Peoria, Illinois 61614
Hospital Services 309-691-1000
Emergency Department 309-691-1069

Hopedale Medical Complex
107 Tremont Street
Hopedale, Illinois 61747
Hospital Services 309-449-3321
Emergency Department 309-449-4490

Unity Point Health Pekin Hospital
600 S. 13th St
Pekin, IL 61554
Hospital Services 309-347-1151
Emergency Department 309-353-0530

Graham Hospital
210 West Walnut Avenue
Canton, Illinois 61520
Hospital Services 309-647-5240

1. A currently licensed **EMR, EMT, Intermediate, Paramedic, or PHRN** may perform emergency and non-emergency medical services as defined in the EMS Act and in accordance with his or her level of education, training and licensure. Prehospital personnel must uphold the standards of performance and conduct prescribed by IDPH in rules adopted pursuant to the Act and the requirements of the EMS System in which he or she practices, as contained in the approved System Program Plan.
2. A person currently licensed as an **EMT, Intermediate, or Paramedic** may only use their EMS license in prehospital/inter-hospital emergency care settings or non-emergency medical transport situations under the written directions of the EMS Medical Director.
3. **Emergency Medical Responder (EMR): Commonly called First Responder:** Provides care consistent with the definition of an EMR service and within the context of Standing Medical Orders (SMOs) or Standard Operating Procedures (SOPs). First Responder care should be focused on assessing the situation and establishing initial care.
   First Responders who provide medical care in the Peoria Area EMS System must be trained in the use of an AED and hold a *First Responder/Defibrillator (FR-D)* recognition card from the Illinois Department of Public Health (IDPH).
4. **Emergency Medical Technician (EMT):** Provides care consistent with the definition of a BLS service and within the context of SMOs or SOPs. This may include interventions involving airway access and maintenance, ventilatory support, oxygen delivery, bleeding control, spinal immobilization and splinting isolated fractures. EMT attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation. In addition, EMTs may assist the patient in self-administering prescribed Nitroglycerin (NTG), Proventil (Albuterol) or an Epi-Pen pending an ALS response. EMTs who are System-certified and functioning with an approved BLS-Med agency may carry and administer various approved medications and procedures.
   AEDs are required on BLS licensed vehicles officially incorporated into the EMS System Plan.
5. **Intermediate (EMT-I):** Provides care consistent with the definition of an ILS provider and within the context of SMOs or SOPs. This may include all BLS skills, along with System-approved interventions and administration of System-approved medications. EMT-Intermediate attention is directed at conducting a thorough patient assessment, providing appropriate care and preparing or providing patient transportation.
6. **Paramedic (EMT-P):** Provides care consistent with the definition of an ALS service and within the context of SMOs or SOPs. This includes all BLS and ILS skills, along with System-approved interventions and advanced life support medications. The patient's condition and chief complaint determine the necessity and extent of ALS care rendered. Consideration should be given to the proximity of the receiving hospital. The Paramedic level may be enhanced to include selected critical care medications and skills for inter-facility transfers.
7. **Prehospital RN (PHRN):** The Illinois EMS Act (1995) defines a PHRN as "a registered professional nurse licensed under the Illinois Nursing Act of 1987 who has successfully completed supplemental education in accordance with rules adopted by the Department (IDPH) pursuant to the Act, and who is approved by an EMS Medical Director to practice within an EMS System as emergency medical services personnel for Prehospital and inter-hospital emergency care and non-emergency medical transports".

NOTE: Pre Hospital Providers and their agency are responsible for tracking their expiration dates and providing updated copies of their licenses to their agency and to the PAEMS Office. If the appropriate documentation is not on file with the PAEMS Office the provider will not be allowed to function within the Peoria Area EMS System.

Listed below is a summary of the important responsibilities of the provider agencies that are in the Peoria Area EMS System. This list is based on the System manuals and IDPH 515 rules and regulations. Illinois administrative code Title 77 Part 515 also known as the 515 codes may be found online at
http://www.ilga.gov/commission/jcar/admincode/077/07700515sections.html

1. A provider agency must comply with minimum staffing requirements for the level and type of vehicle. Staffing patterns must be in accordance with the provider's approved system plan and in compliance with Section 515.830(f).
2. No agency shall employ or permit any member or employee to perform services for which he or she is not licensed, certified or otherwise authorized to perform (Section 515.170).
3. Agencies that utilize EMR's and Emergency Medical Dispatchers shall cooperate with the System and the Department in developing and implementing the program (Section 515.170).
4. A provider agency must comply with the Ambulance Report Form Requirements Policy, including Prehospital patient care reports, refusal forms and any other required documentation.
5. Agencies with controlled substances must abide by all provisions of the Controlled Substance Policy including: *maintaining a security log, maintaining a Controlled Substance Usage Form and* ***reporting any discrepancies to the EMS Office-see PAEMS.org for forms***.
6. Notify the EMS Office of any incident or unusual occurrence which could or did adversely affect the patient, co-worker or the System **within 24 hours** via incident report form found on PAEMS.org.

An agency participating as an EMS provider in the Peoria Area EMS System must notify the Resource Hospital, OSF Saint Francis Medical Center, of the following:

1. Notify the System in **any** instance when the agency lacks the appropriately licensed and System-certified personnel to provide 24-hour coverage. Transporting agencies must apply for an ambulance staffing waiver if the agency is aware a staffing shortage is interfering with the ability to provide such coverage.
2. Notify the System of agency personnel changes and updates **within 10 days**. This includes addition of new personnel and resignations of existing personnel.
3. Notify the System anytime an agency is not able to respond to an emergency call due to lack of staffing. The report should also include the name of the agency that was called for mutual aid and responded to the call.
4. Notify the System of **any** incident, via incident report (found on PAEMS.org) within 24 hours, which could or did adversely affect the patient, co-worker or the System.
5. Provide the System with updated copies of FCC Licenses and Mutual Aid Agreements upon expiration.
6. Notify the System of any changes in vehicles (including temporary replacement). Vehicles must be inspected by the System and the appropriate paperwork must be completed ***prior*** to the vehicle being placed into service.
7. Notify the System if the agency's role changes in providing EMS and/ or response area changes.

Each agency shall appoint a training officer. This EMS training officer must be an IDPH Lead Instructor. The training officer (or approved designee) will be required to attend mandatory training officer in-services at the PAEMS office. This training officer must develop a training plan which meets the requirements for re-licensure and System certification as detailed in the *Continuing Education and Re-licensure Requirements Policy* and submit the agency's training plan (along with a current roster) annually to the EMS Office for System and Department (IDPH) approval. The applications are due by October 1st for the following training year.

All agencies must comply with the Peoria Area EMS System Quality Assurance Plan, including agency self-review, submission of incident reports, and submission of patient care reports or provide electronic access to the agencies charts, maintain controlled substance security logs, glucometer logs, and usage tracking forms.

As a pre hospital provider and/or Agency, it is expected to follow this code of professional ethics:

- Respect all patients regardless of socio-economic status, financial status or background. Dignity includes greeting, conversing, respectful mannerisms, and protecting physical privacy.
- Respect every person's right to privacy. Sensitive information regarding a patient's condition or history should only be provided to medical personnel with an immediate need-to-know. Sensitive information regarding our profession may only be provided to those with a right to know.
- Provide the patient with the best possible care by continuously improving understanding of the profession and maintaining continuing education and required certifications. Protect the patient from incompetent care by knowing the standard of care and being able to identify those who do not.
- Protect the health and well-being of the patient, yourself, your co-workers and the community by constantly following safety guidelines, principles and practices.
- Act within your training, know your limitations, and accept responsibility for both satisfactory and unsatisfactory actions.
- Demonstrate devotion by maintaining confidentiality, assisting in improving morale and not publicly criticizing.
- Demonstrate professionalism by maintaining high moral, ethical and grooming standards. Do not participate in behavior that would discredit you, your co-workers and the profession.

- A fundamental responsibility of the EMS Provider is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color or status.

- Uphold the law and perform the duties of citizenship; as a professional, I further understand that it is a never-ending responsibility to work with concerned citizens and other healthcare professionals in promoting a high standard of emergency medical care to all people.

EMS agencies are expected to advertise in a responsible manner and in accordance with rules, regulations, and statutes to assure the public is protected against misrepresentation.

No agency (public or private) shall mislead, advertise, or identify their vehicle or agency as providing any EMS service unless the agency does, in fact, provide said service as defined in the EMS Act and has been approved by IDPH.

Any person (or persons) who violate the EMS Act, or any rule promulgated pursuant there to, could be subject to legal actions. It is the responsibility of all Peoria Area EMS System providers to report any such infractions of this section to the EMS Medical Director.

Citizens in need of out-of-hospital medical services rely on the EMS System and the existence of state licensure/ certification or national certification to assure that those who respond to their calls for aid are worthy of this extraordinary trust. In light of the high degree of trust conferred upon EMS providers by virtue of licensure and certification, EMS providers should be held to a high standard. For these reasons, the EMS certifying/licensing agency has a duty to exclude individuals who pose a risk to public health and safety by virtue of conviction of certain crimes.

System Certification of individuals convicted of felonies present an unreasonable risk to public health and safety. Thus, applications for certification by individuals convicted of any felony crime are subject to review by IDPH and the System medical director.

IDPH/ PAEMS System Compliance Waiver Policy

If compliance with IDPH Rules and Regulations or the Peoria Area EMS System Policies results in unreasonable hardship, the EMS provider agency shall petition the PAEMS System and IDPH for a temporary rule waiver. They must include the following:

- Cover letter, to include: *agency name, IDPH agency number, agency official(s), agency designated contact person, telephone number, statement of the problem and proposed waiver*.
- Explanation of why the waiver is necessary.
- Explanation of how the modification will relieve problems that would be created by compliance with the rule or policy as written.
- Statement of and justification for the time period (maximum one year) of which the modification will be necessary. This section must also include a chronological plan for meeting total compliance requirements.
- Staffing waivers require local newspaper advertisement explaining staffing shortage, mention that there will be "no reduction in standard of care", and a request for new volunteers/ employees.
- Submit a copy of 60-day staffing schedule.

The petition should be submitted to the Peoria Area EMS System Medical Director for review and approval. The IDPH Regional EMS Coordinator will then review the petition. If needed, the Illinois Department of Public Health may request review of the petition by the State Advisory Board. These recommendations will be forwarded to the Director of IDPH for final action.

HIPAA Policy

Peoria Area EMS System providers are involved in the collection, handling, documentation, or distribution of patient information. Therefore, EMS personnel are responsible for the protection of this information. Unnecessary sharing of confidential information will not be tolerated. Peoria Area EMS System personnel must understand that breach of confidentiality is a serious infraction and violation of HIPAA with legal implications.

Only Peoria Area EMS System personnel and hospital medical staff directly involved in a patient's care or personnel involved in the quality assurance process are allowed access to the patient's medical records and reports. Authorized medical records and billing personnel are allowed access to the patient's medical records and reports in accordance with hospital and EMS provider policies.

The **TWIAGE** app is the preferred method of communications with all participating area hospitals, however, radio communications are a vital component of prehospital care. Information reported should be concise and provide an accurate description of the patient's condition as well as treatment rendered.

Essential components of the communication to the ED

- **Unit identification**
- **Destination & ETA**
- **Age/sex**
- **Chief complaint**
- **Assessment (General appearance, degree of distress & level of consciousness)**
- **Vital signs:**
    1. **Blood pressure (auscultated or palpated if unable to auscultate)**
    2. **Pulse (rate, quality, regularity)**
    3. **Respirations (rate, pattern, depth)**
    4. **Pulse oximetry, if indicated**
    5. **Pupils (size & reactivity)**
    6. **Skin (color, temperature, moisture)**
- Pertinent physical examination findings and SAMPLE history
- Treatment rendered and patient response to treatments

If Medical Control contact is necessary to obtain physician orders (where indicated by protocol), diligent attempts must be made to establish Medical Control contact via:

1. **TWIAGE** app
2. Cellular telemetry (309) 655-6770
3. MERCI radio

If Medical Control contact is not necessary, contact the receiving hospital via the **TWIAGE** app. The **TWIAGE** app may be on a tablet, laptop or cell phone (personal or agency). Any questions about the **TWIAGE** app please contact the EMS office at (309)655-2113 or your agency point of contact. Any EMS Provider may contact Medical Control for any treatments requiring a physician's orders. Delay or failure to contact Medical Control in required situations is a quality assurance qualifier. These Standing Medical Orders or Protocols are to be utilized as Off-Line Medical Control.

High Risk Refusals require Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High risk refusals involve cases where the patient's condition may warrant delivery of care in accordance with implied consent of the *Emergency Doctrine* or other statutory provision.

High risk refusals include, but are not limited to:

- Head injury (based on mechanism or signs & symptoms)
- Presence of alcohol and/or drugs
- Anytime medications are given and patient refuses transport (EMR & BLS)
- Significant mechanism of injury (*e.g.* rollover MVA)
- Altered level of consciousness or impaired judgment
- Minors (17 years old or younger, regardless of injury)
- Situations that involve bypassing a closer hospital

Low Risk Refusals do not require Medical Control consultation (for BLS, ILS & ALS levels) if the prehospital provider determines that the patient meets the *Low Risk Criteria* and there is no doubt that the patient understands the risk of refusal. The patient cannot be impaired and must be able to consent to the refusal. Medical Control should be contacted if there are any concerns about the patient's ability to refuse. Follow the instructions on the PAEMS Refusal form.

If the EMS provider has not been able to contact Medical Control via cellular telemetry, telephone or MERCI radio, the EMS provider must initiate the appropriate protocol(s). Upon arrival at the receiving hospital, an incident report must be completed and forwarded to the EMS Office within 24 hours of the occurrence. This report should document all aspects of the run with specific details of the communications failure and initiation of the Peoria Area EMS System *Standing Medical Orders and Standard Operating Procedures*.

Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired.

1. All EMS providers must complete a patient care report for each patient contact or *request* for response (*e.g.* agency is cancelled en route to a call then a "cancelled call" chart must be completed).

2. If the patient care report cannot be completed prior to departing the ED a **TWIAGE** report or a Peoria Area EMS System *Preliminary Field Medical Report Form* **must** be completed and left with the ED staff. The patient care report should then be completed and faxed to the ED as soon as possible after the call (within the shift).

3. Documentation must be completed on System approved forms and/or System approved electronic reporting systems.

4. Failure to leave written documentation will be reported to the EMS Office by ED personnel. Agencies and/or personnel failing to comply with documentation requirements will be reported to the EMS Medical Director and corrective action may be taken to assure documentation policies and procedures are followed.

5. Non-transport agencies must complete patient care documentation immediately following each call**.**

6. Copies of all patient care reports or access to electronic versions must be provided to the EMS Office.

It is the responsibility of the Resource Hospital to confirm the credentials of the System's EMS providers. System certification is a *privilege* granted by the EMS Medical Director in accordance with the rules and regulations of the Illinois Department of Public Health.

1. The System applicant must be a member of, in a training program, or in the process of applying for employment with a Peoria Area EMS System provider agency.
2. The System applicant must submit PAEMS System Entry Form along with:
    - IDPH license (EMR, EMT, Intermediate, Paramedic, or PHRN)
    - National Registry certification (if applicable)
    - AHA ACLS (Intermediate, Paramedic, PHRN)
    - ITLS/ PHTLS (Intermediate, Paramedic, PHRN)
    - PEPP or AHA PALS (Intermediate, Paramedic, PHRN)
    - CPR {AHA Healthcare Provider OR American Red Cross} (FR-D, EMT, Intermediate, Paramedic or PHRN)
    - Letter of reference from current EMS Medical Director (if applicable)
    - Resume´ (education and employment history)
3. The System applicant must pass the appropriate Peoria Area EMS System Protocol Exam with a score of **80% or higher**. The applicant may retake the exam with the approval of the EMS Medical Director.
4. Successfully complete any practical skills evaluations if requested by the EMS Medical Director.
5. ALS providers must meet with the EMS Medical Director for final approval.
6. Completion of a probation period may be required at the discretion of the medical director
7. The EMS Medical Director reserves the right to deny System provider status or to place internship & field skill evaluation requirements on any candidate requesting System certification at any level.

In addition to minimum continuing education requirements for re-licensure, EMS providers in the Peoria Area EMS System must maintain the following:

EMR Emergency Medical Responder	**24 Hours**	Current BLS CPR Provider Card
EMT Emergency Medical Technician	**60 Hours**	Same as EMR and 80% grade on protocol exam
EMT-I, EMT-P, and PHRN	**80(ILS), 100 (ALS) Hours**	Same as EMT plus current AHA PALS or PEPP, AHA ACLS, and ITLS

Active Provider – The EMS Provider is considered an active provider if they:

- Are System-certified at the level of his/her IDPH licensure level.
- Are active and functions at his/her certification level with a PAEMS System agency providing the same level of service.
- Maintain all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.

Sub-certified Provider – An EMS Provider is considered to be a sub-certified provider if they:

- Are System-certified at a level other than his/her IDPH licensure level.
- Are active and functions as a provider with a PAEMS System agency at a level of service other than his/her IDPH licensure level.
- Maintain all continuing education requirements, certifications, and testing requirements in accordance with System policy for his/her level of System certification.
- RESTRICTIONS:
    - A sub-certified EMS provider may only function within the scope of practice of the individual's System certification and the provider level of the EMS agency.
    - A sub-certified EMS provider is **prohibited** from performing skills the individual is not *System-certified* to perform regardless of the IDPH licensure level.
    - A sub-certified provider is restricted to identifying himself/herself as a provider at his/her level of System certification when functioning with a PAEMS System agency (this includes uniform patches and name tags).

Inactive (Non-participating) Provider – An EMS Provider is considered to be inactive if they were System-certified but have not functioned with a PAEMS System agency for greater than 60 days, and they maintain IDPH CE requirements.

- RESTRICTIONS:
    - An inactive provider is **prohibited** from identifying themselves and performing skills as an EMS provider in the Peoria Area EMS System.
    - An inactive provider must apply for independent re-licensure with IDPH

A System participant who resigns from or is terminated by a System provider agency has a 60-day grace period to re-establish membership/active status with another System provider agency.

1. To be re-licensed as an EMS provider, the licensee must submit the required documentation for renewal with the Resource Hospital (EMS Office) at least **60 days** prior to the license expiration date. Failure to complete these requirements may result in delay or denial of re-licensure. **The licensee will be responsible for any late fees or class fees incurred as a result.**
2. A licensee who has not been recommended for re-licensure by the EMS Medical Director will be instructed to submit a request for independent renewal directly to IDPH.
3. The license of an EMS provider shall terminate on the day following the expiration date shown on the license. An EMS provider may **NOT** function in the Peoria Area EMS System until a copy of a *current* license is on file in the EMS Office.
4. An EMS provider whose license has expired may, **within 60 days after license expiration**, submit all re-licensure material and any late fees to IDPH.
5. Any EMS provider whose license has expired for a period of more than **60 days** may not be re-licensed and must complete all aspects of the initial training program required for licensure and complete all necessary IDPH requirements.

****NOTE**: Failure to re-license at any level does not "automatically" drop a provider to a lower level of certification

6. At any time **prior to the expiration of the current license**, with exception of PHRN the EMS Provider may downgrade their EMS license to a lower level. They must make their request in writing to the medical director and IDPH as well as surrender their current EMS license to the medical director.

7. At any time **prior to the expiration of the current license**, an EMT may revert to the EMR status for the remainder of the license period. The EMT must make this request in writing to the EMS Medical Director & the Department and must submit their original **current** EMT license to the Department.
8. The provider must submit a copy of their new IDPH license to their agency(s) and to the EMS Office.

A patient may refuse medical help and/or transportation. Once the patient has received treatment, he/she may refuse to be transported if he/she does not appear to be a threat to themselves or others. ***Any person refusing treatment must be informed of the risks of not receiving emergency medical care and/or transportation***. NOTE: Family members cannot refuse transportation of a patient to a hospital unless they can produce a valid *Durable Power of Attorney for Healthcare*.

1. Assure an accurate patient assessment has been conducted to include the patient's chief complaint, history, objective findings and the patient's ability to make **sound** decisions.
2. Explain to the patient the risk associated with his/her decision to refuse treatment and transportation, and have the patient complete the "Patient Decision Making Competency Exam".
3. Secure Medical Control approval of all **high risk refusals** (low risk refusals for Emergency Medical Responders) in accordance with the *Online Medical Control Policy*.
4. Complete the *Against Medical Advice/Refusal Form* and have the patient sign the form. If the patient is a minor, this form should be signed by a legal guardian or *Durable Power of Attorney for Healthcare*. **NOTE**: Parental refusals may be accepted by voice contact with the parent (i.e. by telephone) if the EMS Provider has made reasonable effort to confirm the identity of the parent and the form may be signed by an adult witness on scene. This should be clearly documented on the refusal form and in the patient care report.
5. If available, it is preferable to have a police officer at the scene act as the witness. If a police officer is not available, any other bystander may act as a witness. However, his/her name, address & telephone number should be obtained and written on the back of the report.
6. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and refuses to sign the release, clearly document the patient's refusal to sign the report. Also, have the entire crew witness the statement and have an additional witness sign your statement, preferably a police officer. Include the officer's badge number and contact Medical Control.

If the patient elects to be transported they should be transported to the closest appropriate hospital. A patient (or the patient's *Power of Attorney for Healthcare*) does have the right to make an informed decision to be transported to their hospital of choice.

Bypassing the nearest hospital to respect the patient's hospital choice is a decision based on medical benefits and associated risks and should be made in accordance with:

1. Urgency of care and risk factors based on:
   - Mechanism of injury (physiologic factors)
   - Perfusion status and assessment findings (anatomical factors)
   - Transport distance and time (environmental factors)
2. Medical Control consultation
3. Capacity of the nearest facility or facility of choice
4. Available resources of the transporting agency
5. Traffic and weather conditions

The patient's hospital preference may be honored if:

- There are no identifiable risk factors.
- The patient has a secure airway.
- The patient is hemodynamically stable.
- The patient has been advised of the closer hospital.
- Medical Control approves.

The EMS provider must explain the benefits versus the risks of transport to a more distant hospital and contact Medical Control for approval. The patient (or representative) must sign a Peoria Area EMS System *AMA/Refusal Form* documenting that the patient understands the risks. **No transporting service shall bypass a hospital in order to meet an ALS intercept (including Life Flight) unless approved by Medical Control**.

Patients may be transported to the hospital of choice within the city limits of Peoria without contacting Medical Control for approval as differences in transport times is negligible.

All **trauma patients** fall under the American College of Surgeons *Field Triage Decision Scheme*. A trauma patient who meets the ACS Field Triage Guidelines shall be transported to the Level 1 Trauma Center unless otherwise directed by Medical Control.

EMS personnel must not leave or terminate care of a patient if a need exists for continuing medical care that must be provided by a knowledgeable, skilled and licensed provider unless one or more of the following conditions exist:

1. Appropriate receiving hospital personnel assume medical care and responsibility for the patient.
2. The patient or legal guardian refuses EMS care and transportation (In this instance, follow the procedure as outlined in the *Patient Right of Refusal Policy*).
3. EMS personnel are physically unable to continue care of the patient due to exhaustion or injury.
4. When law enforcement personnel, fire officials, or the EMS crew determine the scene to be unsafe and immediate threat to life or injury hazards exist.
5. If Medical Control concurs with a DNR order and/ or cease efforts orders request.
6. Whenever specifically requested to leave the scene due to an overbearing need (*e.g.* disasters, triage prioritization).
7. Medical care and responsibility for the patient is assumed by comparably trained, certified and licensed personnel in accordance with applicable policies.

If EMS personnel arrive on scene, establish contact and evaluate a patient who then refuses care, the EMS crew shall conduct termination of the patient contact in accordance with the *Patient Right of Refusal Policy* and *On-Line Medical Control Policy*.

EMS personnel may leave the scene of an illness or injury incident, where initial care has been provided to the patient and the **only** responsibility remaining for the EMS crew is transportation of the patient or securing a signed refusal under the following conditions:

1. Delay in transportation of another patient (i.e. trauma patient) from the same incident would threaten life or limb.
2. An occurrence of a more serious nature elsewhere necessitates life-saving intervention that could be provided by the EMS crew (and without consequence to the original patient).
3. More appropriate or prudent transportation is available.

During the transport of a patient by ambulance, should the EMS crew come across an emergency requiring ambulance assistance; the local EMS system will be activated. Crews involved in the treatment and transportation of an emergency patient are not to stop and render care. The priority is to the patient onboard the ambulance. In the event you are transporting the patient with more than two (2) appropriately trained prehospital personnel, you may elect to leave one medical attendant at the scene to render care and the other personnel will continue to transport the patient to the receiving facility. A smooth transition of care between EMS providers is essential for optimum patient care. First Responder and BLS crews routinely transfer care to transporting EMS providers. The transfer of advanced procedures presents unique concerns for both the EMS provider relinquishing patient care as well as the EMS provider assuming patient care. Cooperation between all EMS personnel is encouraged and expected. Once on scene, the EMS transporting agency shall, in conjunction with Medical Control, be the on-scene authority having jurisdiction in the determination of the patient care plan. The rank or seniority of a *non-transport provider* shall not supersede the authority vested in the transporting EMS provider by the EMS Medical Director. Upon the arrival of the transporting agency, the non-transport provider should provide a detailed verbal report, and if available, utilize **TWIAGE** to transfer all communications and then **immediately transfer care to the transporting provider**.

Intercept Policy-

If a patient's condition warrants a higher level of care and an advanced level is available, then the more advanced agency may be called for immediate assistance. Conditions warranting advanced assistance include, but are not limited to:

- Trauma patients entrapped with extrication required.
- Patients with compromised or obstructed airways.
- Respiratory and Cardiac arrests.
- Patients exhibiting signs of hypoxemia (*e.g.* respiratory distress, restlessness, cyanosis) unrelieved by oxygen.
- Patients with altered mental status/altered level of consciousness.
- Chest pain of cardiac nature unresolved with rest, oxygen and/or nitroglycerin.
- Patients exhibiting signs of decompensated shock (BP<100mmHg, pallor, diaphoresis, altered LOC, tachypnea).
- Unconscious or unresponsive patients (other than a behavioral episode).
- Any case in which the responding agency or Medical Control deems that advanced care would be beneficial to patient outcome.
- Pediatric cases with any of the conditions listed above.

Regardless of the response jurisdiction, if two (2) different agencies with different levels of care are dispatched to and arrive on the scene of an emergency, *the agency with the highest certification level shall assume control of the patient*.

The following guidelines also apply:

- Patients should not be transferred from ambulance-to-ambulance. The higher-level personnel, along with proper portable equipment, shall board the requesting agency's ambulance.
- The higher level personnel will oversee patient care with the assistance of the requesting agency's personnel.
- Once the higher level personnel have boarded the requesting agency's ambulance, the higher level provider will determine the transport code for the remainder of transport:

In the event that a PAEMS System approved ALS or ILS Provider is used to assist a BLS Provider an **in-field service level upgrade*** can be utilized to optimize patient outcome. To provide guidelines for infield upgrades of ambulances to higher level of care.

In certain circumstances, it may become necessary to upgrade BLS vehicles to the Intermediate or Advanced Life Support level. In the event that it becomes necessary to upgrade a BLS ambulance, the following steps must be followed:

The BLS ambulance must be approved by the PAEMS System to function as an ALS or ILS ambulance for the duration of this staffing arrangement.

•ALS or ILS personnel may board a BLS ambulance to render a higher level of prehospital emergency care thereby temporarily upgrading that BLS ambulance to the status of ALS or ILS.

•All portable ALS or ILS equipment as listed in the PAEMS Ambulance Supply List must be present on the BLS ambulance.

•The ALS or ILS personnel will assume responsibility for the treatment and transport of patients while on the up graded ambulance. BLS providers may assist with patient care on scene and during transport if requested.

•Once the patient has been transported to the hospital and the call terminated, the ALS or ILS equipment may be removed from the EMS unit, or properly secured as to not be utilized by BLS personnel, and it will return to its BLS certification level.

Prehospital care providers shall complete a Peoria Area EMS System (or the individual agency) *Incident Report Form* whenever a System related issue occurs. These reports are for informational QA/QI purposes only and shall be treated as such. The following information needs to be provided on the form:

1. Date of occurrence
2. Time the incident occurred
3. Location of the incident
4. Description of the events
5. Personnel involved
6. Agency and/or institution involved
7. Copy of the patient care record and/or any other related documents

1. All incident report forms shall be given to the EMS provider's chief, supervisor, training officer, or quality assurance coordinator who will assess the incident and will forward the report to the Peoria Area EMS System Quality Assurance Coordinator.

2. The EMS QA Coordinator will review the incident and notify the EMS Medical Director and the appropriate course of action will be determined.

3. The EMS provider originating the report will be notified of the resolution.

Situations requiring EMS Office notification include:

- Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or the System.
- Any deviation from Peoria Area EMS System policies, procedures or protocols.
- **Medication and/ or Treatment errors and Equipment failures**
- Delays in patient care or scene response
- Medical Control contact was indicated but unavailable
- Violence toward EMS providers that results in injury or prevents the provider from delivering appropriate patient care
- Inappropriate Medical Control orders
- Repeated concerns/conflicts between agencies, provider/physician or provider/hospital conflicts
- Patterns of job performance that indicate skill decay or knowledge deficiencies affecting patient care

Situations subject to review and resolution at the agency level include:

- Conflicts between employees, agencies, or issues that do not adversely affect patient care.

Unsuccessful cardiopulmonary resuscitation (CPR) and other interventions may be discontinued or not performed following consultation with Medical Control. Circumstances for this are listed below:

- Prolonged resuscitation efforts (either BLS alone or combined BLS and ALS) beyond 15 minutes without a return of spontaneous circulation or shockable rhythm are usually futile, unless cardiac arrest is compounded by hypothermia, submersion in cold water.
- Full ACLS has been instituted (ALS/ILS) to include rhythm analysis and defibrillation if indicated, appropriate airway management, and three rounds of the appropriate ACLS medications are given without return of spontaneous circulation.
- Extrication is prolonged (>15 minutes) in a pulseless, apneic patient, with no resuscitation possible during extrication (hypothermia is an exception).
- Patient has a valid DNR where resuscitation efforts were initiated prior to knowledge of DNR status.
- Correctable causes or special resuscitation circumstances have been considered and addressed without positive results.
- Per family request.

Document all elements of patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement and medical control in the EMS patient care report (PCR).

This **Do Not Resuscitate (DNR)** policy is a tool to be used in the prehospital setting to set forth guidelines for providing CPR or for withholding resuscitative efforts. The purpose of this policy is to specify requirements for valid DNR orders and to establish a procedure for field management of these situations.

A DNR policy shall be implemented only after it has been reviewed and approved by the Illinois Department of Public Health in accordance with the requirements of **Section 515.380 of the Illinois Administrative Code.**

1. Any EMR, EMT, Intermediate, Paramedic or PHRN who is actively participating in a Department approved EMS system may honor, follow and respect a valid DNR. Medical Control must be contacted in all cases involving a DNR.

2. By itself, a DNR order does not mean that any other life-prolonging therapy, hospitalization or use of EMS is to be withheld. DNR orders do not affect treatment of patients who are not in full arrest (pulseless and breathless).

3. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR may or may not be in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist:

    - Obvious signs of biological death are present.
    - Death has been declared by the patient's physician or the coroner.
    - A valid POLST is present and the EMS provider has made reasonable effort to verify the identity of the patient named in the order (i.e. identification by another person, ID band, photo ID or facility, home-care or hospice nursing staff).
    - If the above signs of death are recognized, EMS personnel must contact Medical Control to confirm the decision not to attempt resuscitation prior to contacting the coroner.

- If the patient's primary care physician is at the scene of (or on the phone) and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity (if not known to the EMT) and notify Medical Control of the request of the on-scene physician. Follow Medical Control orders.
- The only recognized POLST form EMS providers are obligated to honor, follow & respect is the standardized Illinois POLST form which has the Seal of the State of Illinois in the upper left corner. All signature lines must be completed in order for the DNR to be valid.
- Any other advance directives or "living will" cannot be honored, followed and respected by pre-hospital care providers. EMS personnel must contact Medical Control for direction regarding any other type of advanced directive. Resuscitation should not be withheld during the process of contacting or discussing the situation with the on-line Medical Control physician.
- A Durable Power of Attorney for Healthcare is an agent who has been delegated by the patient to make any healthcare decisions (including the withholding or withdrawal of life-sustaining treatment) which the patient is unable to make. The durable Power of Attorney for Healthcare agent must provide positive identification (i.e. driver's license, photo ID, etc.)
- Revocation of a written POLST order is accomplished when the POLST order is physically destroyed or verbally rescinded by the physician who signed the order and/or the person who gave consent to the order.
- Prehospital care providers have a duty to act and provide care in the best interest of the patient. This requires the provision of full medical and resuscitative interventions when medically indicated and not contraindicated by the wishes of the patient.
- When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear unclear (i.e. upset family members, disagreement regarding DNR order, etc.), EMS personnel should provide assessment, initiate resuscitative measures and contact Medical Control for further direction.
- Appropriate patient care reports will be completed on all patients who are not resuscitated in the prehospital setting. A copy of the POLST form should be retained and attached as supporting documentation to the prehospital care report form.

It is the policy of the Peoria Area EMS System that CPR need not be initiated when death has been determined based on the criteria outlined below. Peoria Area EMS providers are required to contact Medical Control for determination of death covered in this policy. Clinical signs of death include, but are not limited to the following:

Medical

- Unresponsiveness
- Rigor mortis
- Presence of venous pooling in the body
- Incineration or extensive full thickness burns
- Transection of head or trunk
- Major blunt or penetrating trauma
- Deforming brain injury
- Lividity and/or any degree of generalized cyanosis
- Separation of heart and/or brain
- Deforming brain injury
- Decapitation
- Decomposition
- Pulselessness
- Non-reactive pupils

Trauma

- Absence of vital signs in a trauma victim upon arrival of EMS personnel despite a patent airway.

Do not initiate resuscitation in the following:

Do Not Resuscitate orders: No resuscitation efforts should be initiated when the person or family has evidence of a valid Do Not Resuscitate (DNR) order in hand.
Scene safety: The physical environment is not safe for the EMS providers to enter.
Infant death (SIDS): An infant who is apneic, and meets the above criteria may be presumed dead.
Neonatal death: A neonate who is apneic, pulseless, and exhibits neonatal maceration (softening or degeneration of the tissues after death in utero), anencephaly (absence of a major portion of the brain, skull, and scalp), or if the gestational age is less than 22 weeks and neonate shows signs of obvious immaturity (translucent and gelatinous skin, lack of fingernails, fused eyelids) may be presumed nonviable.

Notes:

- Resuscitation may be initiated if the condition of the scene indicates that withholding resuscitation could cause a potential unsafe condition for the ambulance crew.
- If the EMS providers determine the situation warrants removal of the patient from the scene, resuscitation efforts must be initiated and continued throughout transportation to the hospital and the details documented in the patient care report.

Coroners Notification:

In accordance with Section 10.6, Chapter 31 of the Illinois Revised Statutes –

1. Every law enforcement official, funeral director, EMS provider, hospital director of administration or person having custody of the body of a deceased person, where the death is one subjected to investigation under Section 10 of this Act, and any physician in attendance upon such a decedent at the time of his death, shall notify the coroner promptly.
2. Deaths that are subject to coroner investigation may include but are not limited to:

- Accidental deaths of any type or cause
- Homicidal deaths
- Suicidal deaths
- Abortions – criminal or self-induced maternal or fetal deaths

- Sudden deaths – when in apparent good health or in any suspicious or unusual manner including sudden death on the street, at home, in a public place, at a place of employment, or any deaths under unknown circumstances may ultimately be the subject of investigation.

3. The coroner (or his/her designee) should be provided the following information:

- Your name
- Your EMS service
- Location of the body or death
- Phone number and/or radio frequency you are available on
- Brief explanation of the situation

4. Once this information has been provided, wait for the coroner (or his/her designee) to arrive for further instructions. EMS crews may clear the scene if law enforcement is on the scene and no other emergency exists.
5. Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified.
6. If a patient is determined to be dead during transport, note the time & location and record this information on the patient care report. Immediately contact the coroner to discuss death jurisdiction. Do not cross county lines with a patient that has been determined to be dead.

EMS providers should be aware of law enforcement's concern for preserving, collecting and using evidence. Anything at the scene may provide clues and evidence for the police.

Crime Scene Policy

1. Immediately notify law enforcement of any suspected crime scene (this does not necessarily include petty crimes or traffic violations).

2. If the victim is obviously dead, then he or she should remain undisturbed if at all possible.

3. Do not touch, move or relocate any item at the scene unless absolutely necessary to provide treatment to an injured, viable victim. Mark the location of any item that must be moved so the police can determine its original position.

4. Restrict access to the scene of onlookers or other unauthorized personnel on the premises of the crime.

5. Observe and note anything unusual (e.g. smoke, odors, or weapons), especially if the evidence may not be present when law enforcement arrives.

6. Give immediate care to the patient. The fact that the patient is a probable crime victim should not delay prompt care to the patient. Remember that your role is to provide emergency care, not law enforcement.

7. Keep detailed records of the incident, including your observations of the victim and the scene of the crime. Lack of records about the case can be professionally embarrassing if called to testify.

EMS providers should consider the mental health needs of a patient who appears emotionally or mentally incapacitated. This involves cases that the EMS provider has reasonable cause or evidence to suspect a patient may intentionally or unintentionally physically injure himself/herself or others, is unable to care for his/her own physical needs, or is in need of mental health treatment against his/her will.

This does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years and the patient is under the supervision of family or another healthcare provider, unless the family or healthcare provider has activated EMS for a specific behavioral emergency.

1. Attempt to persuade the patient that there is a need for evaluation and transport to the hospital.

2. If persuasion is unsuccessful, contact Medical Control and relay the history of the event. Clearly indicate your suspicions and/or evidence and have the medical control physician discuss the patient's needs with the parties involved in the situation.

3. The EMS crew must then follow the direction of the medical control physician in determining the disposition of the patient or termination of patient contact. Another agency's or party's opinion should not influence the EMS provider's assistance to a mental health need.

4. Under no circumstances does transport of the patient, whether voluntarily or against his/her will, commit the patient to a hospital admission. It simply enables the EMS providers to transport a person suspected to be in need of mental health treatment.

5. If a patient is combative or may harm self or others, call law enforcement for assistance and follow the *Patient Restraint Policy*.

Patients may only be restrained if clinically justified! The use of restraints shall only be utilized if the patient is violent and may cause harm to themselves or others. Physical and/or chemical restraints are a last resort in caring for the emotionally disturbed patient.

1. To safely restrain the patient, use an appropriate number of personnel.
2. If available, EMS may use police protective custody.
3. Attempt to calm the patient and explain the procedure to the patient (and family) if possible.
4. If attempts at verbal de-escalation have failed and the decision is made to use restraints, do not waste time bargaining with the patient.
5. Remember to remove any equipment from your person which can be used as a weapon against you (e.g. trauma shears).
6. Move the patient to a backboard or the stretcher supine and place soft, disposable restraints on all 4 limbs and fasten to the backboard or stretcher.
7. Contact Medical Control as soon as possible for any additional guidance, however, do not delay safety of the crew and/ or the patient.
8. Transport as soon as possible.
9. Document circulation checks every 15 minutes (of all restrained limbs) and thoroughly document the reasons for applying restraints, time of application, condition of the patient before and after application, method of restraint and any law enforcement involvement, including any use of law enforcement equipment (e.g. handcuffs) and the time Medical Control was contacted.
10. Do not remove restraints until released by medical personnel at the receiving hospital.

Chemical Restraints Policy/Procedure: Behavioral episodes may range from despondent and withdrawn behavior to aggressive and violent behavior. Behavioral changes may be a symptom of a number of medical conditions including head injury, trauma, substance abuse, metabolic disorders, stress and psychiatric disorders. Patient assessment and evaluation of the situation is crucial in differentiating medical intervention needs from psychological support needs.

ILS Care should be directed at continuing or establishing care, continuing EMR and BLS care, conducting a thorough patient assessment, ensuring personal safety and preparing for or providing patient transport.

1. If the patient is a threat to self or others, restrain the patient and contact Medical Control as soon as possible. An order for restraints is a must.
   - If after physical restraint the patient is still a risk to self or others consider chemical restraint.
2. **Midazolam (Versed)**: Intranasal Versed may be used for sedation **if absolutely necessary**. (See intranasal dosing sheet) **Contact Medical Control** for further orders.
3. Initiate transport as soon as possible.

ALS Care should be directed at continuing or establishing care, continuing EMR, BLS, & ILS Care, conducting a thorough patient assessment, ensuring personal safety and preparing for or providing patient transport.

1. **Haloperidol (Haldol)** Administer **Haloperidol**, 5mg IM and **Midazolam (Versed)**: 2mg IM. May repeat if needed after 10 minutes if patient is not manageable.
2. If Severe: Violent, Combative, dangerous, proceed to:
   Ketamine: Ketamine 4mg/kg IM
3. Initiate transport as soon as possible.
4. After Patient is sedated, ***you must initiate continuous cardiac and respiratory monitoring including EKG Monitor, Pulse Oximetry, and waveform ETCO2***. Apply oxygen as tolerated or needed after sedation.

Critical Thinking Elements

- Verbally attempt to calm and/or re-orient the patient to reality.
- **If restraints are used, thoroughly document the reasons for applying restraints, time of application, condition of the patient before and after application, method of restraint and any law enforcement involvement, including any use of law enforcement equipment (e.g. handcuffs) and the time Medical Control was contacted.**
- Consider medical etiologies of apparent behavioral disorders such as **hypoxia**, stroke/head bleed, substance abuse/overdose, and hypoglycemia.
- **Document response to sedation including vital signs, Rhythm, Pulse Ox and ETCO2.**
- **Haldol** may precipitate dystonic reactions including Restlessness, Tics, and Muscle Rigidity. If suspected, give **Benadryl** 25mg IV or IM.
- When using Ketamine, be aware of Side Effects
  Laryngospasm: this very rare adverse reaction presents with stridor and respiratory distress.

  Emergence reaction: presents as anxiety, agitation, apparent hallucinations or nightmares as ketamine is wearing off. For severe reactions, consider Versed 2mg IM or IV.

  Nausea and Vomiting: always have suction available after ketamine administration.

Only personnel licensed to perform care in the prehospital setting and certified in the Peoria Area EMS System are allowed to provide patient care the scene unless approved by Medical Control.

An on-scene physician (or other medical professional) does not automatically supersede the EMS provider's authority. Patient care shall not be relinquished to another person or provider unless approved by the EMS Medical Director or Medical Control.

1. If a professed, duly licensed medical professional (e.g. physician, nurse, or dentist) wishes to participate in and/or direct patient care on scene, the EMS provider should contact Medical Control and inform the base station physician of the situation.

2. If the medical professional on scene (including the patient's primary care physician) has properly identified himself/herself and wishes to direct patient care, the medical control physician must grant approval prior to acting on the on-scene medical professional's request. If care is relinquished to the professional on scene, he/she must accompany the patient to the hospital. This procedure should be explained to the provider prior to contacting Medical Control.

3. If an on-scene physician orders procedures or treatments that the EMS provider believes to be unreasonable, medically inaccurate, and/or outside the EMS provider's standard of care, the EMT should refuse to follow such orders and re-establish contact with Medical Control. In all circumstances, the EMS provider shall avoid any order or procedure that would be harmful to the patient.

4. If an on-scene medical professional (or any person claiming to be a healthcare provider) is obstructing EMS efforts or is substantially compromising patient care, the EMS provider should request law enforcement assistance and communicate the situation to Medical Control.

5. If EMS personnel or nursing staff from another system or jurisdiction (other than a requested intercept or mutual aid) are at the scene and request to provide or assist with patient care these personnel may provide assistance with the supervision of the agency having jurisdiction of the scene. Peoria Area EMS System policies, procedures and protocols must be followed regardless of the assisting EMS personnel's authorized level of care.

The purpose of this policy is to outline common expected procedures for intervening with patients and/or their families who under the law may be carrying a concealed deadly weapon. The intent is to reduce the potential risk of injury to emergency responders, healthcare personnel and the public. This policy aims to mutually respect the rights of citizens who lawfully carry a concealed weapon as well as to provide safety for emergency responders and healthcare providers.

This policy pertains to all weapons, including, but not limited to firearms, hunting knifes, and electronic weapons.

1. No weapon will ever be transported unsecured inside the ambulance whether belonging to the patient or family member. The only exception to this rule will be for on duty law enforcement personnel.
2. **Assume all weapons are loaded. Never attempt to unload a firearm, or engage the safety.**
3. If a patient refuses to remove or allow removal of the weapon, that patient is considered to be refusing medical care and the scene now unsafe. EMS personnel should leave and wait for Law Enforcement to secure the scene.
4. Optimally, a patient with a concealed weapon away from their residence should have it taken control of by local law enforcement. The goal is for the EMS provider to minimally handle any weapon
5. If patient has a weapon, and is able, ask them to lock up their weapon at home or in the trunk of their vehicle.
6. The weapon may be removed by properly trained EMS personnel, tagged with patients name and secured in a lockbox.
7. If weapon is located while transporting a patient, the ambulance should be stopped, weapon tagged with patient's name, secured in a lockbox.
8. If a weapon is found in a holster, the weapon should remain in the holster while it is secured.
9. When a weapon is encountered on a call, the patient care report should include documentation that a weapon was located, type of weapon, how it was recovered, where it was located, what the disposition was, and any actions or comments made to or by the patient.

Transfer of Weapon:

1. Each hospital will have its own procedure when it comes to dealing with secured weapons that arrive by EMS. If you are unsure of the receiving hospital's policy, please inquire with their staff on your arrival.
2. When transporting a patient notify the receiving facility that security will need to meet you to take control of the patient's personal property, and locked in their designated safe location.
3. A "Transfer of Personal Property" form must be completed and signed by all parties.

The purpose of this page is to educate and inform our EMS providers concerning the designated areas where carrying firearms is prohibited according to **Section (65.) of the Firearm Concealed Carry Act.**

The following procedure has been established in accordance with the Illinois State Statutes, Centers for Disease Control recommendations and OSHA standards. All Peoria Area EMS System agencies should have a specific exposure control program and post exposure plan.

1. Utilization of body substance isolation gear during all patient contacts is an effective means of avoiding exposure to bodily fluids. EMS personnel should don protective gear prior to entering a scene or situation that may increase the risk of exposure to bodily fluids or other potentially infectious agents.

2. Thorough hand washing should be accomplished immediately after each patient contact or handling of potential infectious vectors.

3. EMS personnel should consult their agency's exposure control program for specific guidelines in the type of protective gear, policies, and procedures.

An exposure incident has occurred when, as a result of the performance of an EMS provider's duty, the provider's eyes, mouth, mucous membrane or area of non-intact skin has come in contact with body fluids or other potentially infectious vector. This includes parenteral contact with blood or other potentially infectious materials. If EMS personnel treating and/or transporting a patient are directly exposed to a patient's body fluids or infectious vector, the provider(s) should immediately report the incident. This includes notifying the EMS provider's supervisor, obtaining the Peoria Hospitals Communicable Disease Incident Form and following post exposure procedures.

1. Thoroughly cleanse the exposed area with soap and water immediately.

2. The eyes and/or mouth of the provider should be thoroughly rinsed with water if exposed.

3. Immediately seek treatment at the emergency department where the source patient was transported. If the source patient was not transported to an emergency department, treatment should be sought at a local hospital (emergency department).

4. Complete the Peoria Hospitals Communicable Disease Incident Form. The completed form should be sealed in an envelope addressed with the words "Attention Infection Control" and be left with the emergency department charge nurse. The charge nurse will forward the envelope to the infection control department. The EMS provider should also provide a copy to his/her supervisor and to the EMS Office within 24 hours.

5. A request should be made for consent to test the source patient's blood for HBV/HCV/HIV infectivity. If consent is granted, a blood sample shall be drawn and results of testing documented. Testing is not necessary if the source patient is known to be infected with HBV or HIV.

6. Results of tests performed on the source patient shall be made available to the exposed EMS provider's private or occupational physician while maintaining confidentiality of all persons involved.

7. The exposed EMS provider will be given the opportunity for a blood specimen collection and testing to determine baseline assessment for HBSAB/HIV. If the EMS provider does not wish to be tested, the blood sample must be maintained for 90 days. The EMS provider may consent to testing at any time within that period.

8. The EMS provider should follow-up with his/her private or occupational physician and the provider should be advised of available post-exposure counseling.

9. All findings or diagnosis shall remain confidential.

Questions concerning exposure control program requirements or post exposure procedures should be directed to the EMS provider's supervisor, training officer or infection control dept.

1. If a patient is suspected to have, or is diagnosed with a reportable communicable disease, a copy of the ambulance patient care report will be forwarded to Infection Control Department as soon as possible by the receiving hospital emergency department supervisor.

2. The Infection Control Department will maintain a log and file. If any patients treated and/or transported by EMS providers are diagnosed as having one of the specified diseases, the designated EMS provider(s) will be notified by the Infection Control Department within seventy-two (72) hours after the confirmed diagnosis is known.

3. Specified diseases requiring notification of EMS personnel by the Infection Control Department may include but not limited to:

- Acquired Immunodeficiency Syndrome (AIDS)*
- AIDS-Related Complex (ARC)*
- Anthrax
- Chickenpox
- Cholera
- Novel Coronavirus (Covid 19)
- Diphtheria
- Hepatitis B
- Hepatitis non-A, non-B
- Herpes simplex
- Human Immunodeficiency Virus (HIV) infection*
- Measles
- Meningococcal infections
- Mumps
- Polio
- Rabies (human)
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Smallpox
- Tuberculosis (TB)
- Typhus

*For confirmed diagnosis of AIDS or HIV, the letter of notification will not be sent unless emergency personnel indicate that they may have had blood or body substance exposure

PURPOSE:
OSF HealthCare and OSF EMS Systems is committed to providing an environment free of the negative effects of substance abuse. Substance abuse is strictly prohibited while on duty and while at OSF.

DEFINITIONS:
Prohibited Substances - Prescription drugs used inconsistent to the EMS provider/student's legitimate prescription, unauthorized controlled substances or prescription drugs, illegal drugs, marijuana, alcohol, or otherwise lawful substances abused by an EMS provider/student because of the substance's intoxicating effects.

1. **Prohibited Substances** do not include substances which are prescribed to an EMS provider/student and intended to be delivered and administered to the EMS provider/student as a patient under the care of a physician or by an authorized healthcare provider. However, the possession and/or use of such substances must be consistent with the prescription provided to the EMS provider/student, must comply with OSF's Drug Free Workplace (246) policy, and the EMS provider/student must not be impaired while on duty or on OSF property.

Otherwise lawful substances abused by an EMS provider/student because of the substance's intoxicating effects include, but are not limited to, lawful substances such as over-the-counter medications, paints, thinners, solvents, etc. that may cause impairment while on duty.
Substance Abuse - The use, possession, or distribution of **Prohibited Substances**.

POLICY:

1. OSF EMS Systems recognizes that safety and productivity is compromised by substance abuse which increases the potential for accidents, substandard performance, and damage to the reputation of OSF.
2. Any EMS provider/student at OSF is prohibited from: a) reporting to duty under the influence of Prohibited Substances, b) distributing Prohibited Substances while on duty, or c) possessing Prohibited Substances at OSF.
3. Any prehospital provider who has been informed, or has reason to believe or suspect that use of a substance (prescription or non-prescription) may present a safety risk or may otherwise impair an EMS provider/student's conduct and/or performance, must immediately report such substance use to the EMS Medical Director or his/her designee.
4. Any EMS provider/student whose use of substance jeopardizes the safety of themselves, patients, co-workers and/or bystanders, will be deemed "unfit for work" and subject to required drug and/or alcohol testing.
5. Any EMS provider/student who violates this Substance Abuse policy, except those who self-identify and request assistance as explained below, will be removed from the EMS program. This may be done after only one occurrence and may result in license decertification in the EMS system at the discretion of the EMS Medical Director.
    a. Recertification and/or readmission to the EMS program is discretionary and may only be done after the EMS provider/student has successfully received appropriate treatment, as determined by the EMS Medical Director.

EMS Provider/Student Responsibility

1. OSF EMS Systems do not require EMS provider/student to submit to blood and/or urine testing for Prohibited Substances as a routine part of initial system certification. However, individual EMS agencies may require testing as part of their employment application process.
2. It is the responsibility of the EMS provider/student to seek help before substance abuse leads to job impairment, poor performance or unsafe behavior while on duty.

Testing Protocol

1. Any EMS provider/student who violates this policy, or if there is reasonable cause to suspect an EMS provider/student is under the influence of Prohibited Substances while on duty, will be required to submit to drug and/or alcohol testing.
2. The EMS Medical Director will determine the appropriate screening as part of an investigation.
    a. The cost of this testing will be the EMS provider/student's responsibility. Disputes related to billing of drug testing should not delay the procedure(s).
3. An EMS provider/student who refuses to cooperate with required drug and/or alcohol testing, or is caught tampering with or attempting to tamper with his/her test specimen (or the specimen of any other prehospital provider), will be subject to disciplinary action, which may include permanent suspension/decertification from the EMS system.
4. If any of the test results are positive (including THC/marijuana metabolites), the EMS Medical Director will interview the EMS provider/student. The EMS Medical Director will consult with the EMS provider/student's agency to determine if referral to an assistance program will occur.

Assistance and Disciplinary Process for Substance Abuse

OSF considers substance abuse and addiction to be a serious health problem warranting appropriate evaluation and treatment. As such, OSF EMS Systems are prepared to assist any EMS provider who has developed dependency on drugs and/or alcohol. The EMS Systems, and ultimately our patients, suffer adverse effects of an impaired provider struggling with substance abuse and addiction. As such, any EMS provider/student participating in an OSF EMS System who voluntarily requests assistance for issues related to substance abuse or addiction may contact their agency or the EMS Office for further resources and guidance.

1. Any EMS provider/student who self-identifies prior to being tested or seeks help for substance abuse will be provided resources and guidance on an appropriate assistance program. In this instance, the EMS provider/student will be suspended from the EMS program while they seek treatment; however, this will not result in license decertification in the EMS System and the EMS provider/student will be readmitted to the EMS program after successfully receiving appropriate treatment, as determined by the EMS Medical Director.
2. Any EMS provider/student who violates this policy and/or whose test results are positive will be removed from the EMS program and their license may be decertified. The EMS Office will provide resources and guidance on an appropriate treatment program. Recertification and/or readmission to the EMS program is discretionary and may only be done after the EMS provider/student has successfully received appropriate treatment, as determined by the EMS Medical Director.
    a. If the EMS provider/student refuses to seek treatment, they will be removed from the EMS program and their license will be decertified.
3. Any EMS provider/student returning to the EMS program following treatment for substance abuse may be subject to periodic and unannounced drug and/or alcohol testing on a schedule and for a duration established by the EMS Medical Director.

ILS and ALS vehicles are to carry controlled substances as required by the regulatory system protocol. Due to the nature of these medications, there is a high potential for abuse, thus the FDA has labeled them controlled substances. As such, there must be a high degree of accountability and security which are the responsibility of the agency and its employees. This policy is to be enforced at all times. Regular checks will take place to ensure compliance with this policy.

Note: Although this policy was enacted to be consistent with DEA guidelines at the time of its development, unique situations may cause DEA inspectors to require alternative storage solutions. This policy is subject to change and adapt to any and all updates that may be deemed necessary by the DEA.

Controlled substances for patient use will be contained in a numbered box/container secured with a numbered, tamper resistant seal.

Controlled Substance Storage – Safes

An inventory of controlled substances are maintained and secured in a limited access safe located in a temperature controlled location. Access is limited to designated agency personnel and PAEMS personnel. Designated personnel will validate the inventory of the safe and sign off on the PAEMS Controlled Substance Restock Inventory & Accountability form. During the count, controlled substances must be examined for vial/ampule integrity, medication clarity, and expiration date. Any issues must be reported to the agency's designated official and the controlled substance secured for waste (see Disposal of Controlled Substances). This inventory process requires two signatures. During the count, limit any distractions.

Restocking of Safes

The process of restocking inventory for any safe will be managed by the designated agent. As staff/agents identify approaching minimum par levels of controlled substance inventories, a request must be made to the designated agent that orders controlled substances indicating the medication and quantity required to return an adequate supply not to exceed max par. The designated agent will submit the request to OSF Pharmacy in Peoria via the Medication Charge Sheet. When the order is filled, the agent will retrieve the order and deliver to the safe requiring restock. OSF Pharmacy will generate a DEA Form 222 of which the "purchaser" copy will be maintained at the location where the controlled substance is stored. Each location maintaining a safe will possess their appropriate DEA 222 forms and display their DEA and State of Illinois registration certificates. The added controlled substances must be recorded on the PAEMS Controlled Substance Restock Inventory & Accountability form.

222 Form Renewal/Restock

222 Forms will be used when restocking/purchasing Schedule 2 Controlled Substances. 222 forms are ordered and restocked by the OSF Pharmacy. The 222 restock forms will be mailed to the agency. It is the responsibility of the agency to bring the 222 forms to the OSF Pharmacy in a timely manner.

Controlled Substance Storage – Boxes

Boxes are to be secured in an onboard safe or locking cabinet on the unit in service. Boxes are to begin each shift with appropriate sealed tag and replaced, as soon as possible, after medication is used.
All controlled substance boxes are to be accounted for on PAEMS Controlled Substance Box Location Form.

Restocking of boxes

Whether the controlled substance was administered to a patient, found to be expired, or damaged, it must be replaced when possible. When restocking, the designated agent may access the safe and retrieve the specific medication, placing it in the box. Seals must be logged on the PAEMS Controlled Substance Usage Log after

the box is retagged. Documentation of the removal of the medication from the safe must also be logged subtracting from the safe and adding to the box on PAEMS Controlled Substance Restock Inventory & Accountability Form. New box information must also be logged on PAEMS Controlled Substance Box Location Form.

Inventory Discrepancy

If for any reason any inventory is not correct, and/or a discrepancy is discovered, immediate notification to the designated agent and the PAEMS Medical Director is required and an immediate investigation will be initiated.

21 CFR 1304.11 (c)

The Code of Federal Regulations Title 21 Part 1304 Section 1304.11 – Inventory Requirements item (c) requires a biennial inventory. The designated agent will inventory the agency's controlled substances on a monthly basis logging counts for the purpose of compliance with the Department of Justice's Drug Enforcement Administration. The monthly inventory may consist of a joint inventory/audit in the presence of PAEMS personnel (see PAEMS Audit). The record will contain the following information: record of the date, time, counts, and two signatures.

Administration and seals

Intermediates, Paramedics, Critical Care Paramedics or PHRNs administering a controlled substance during the course of their shift, or if a seal was broken throughout shift will be required to complete an entry on the PAEMS Controlled Substance Usage Log in the narcotic box.

Damaged seals or broken contents of boxes will be reported to (and is the responsibility of) the designated agent. All such incidents will require a PAEMS Incident Report.

Disposal of Controlled Substances

All unused controlled substances must be wasted and disposed in accordance with the proper system protocols.

Unused controlled substances will be wasted only in the presence of a witness, i.e. nurse, physician, or agency staff member. Furthermore all drug containers, vials, syringes etc. must be properly disposed of in a proper biohazard container, also in the presence of a witness.

In the event not all of the controlled substance is administered to a patient, the remainder will be slowly expelled into an absorbent material. All waste must be documented on the PAEMS Controlled Substance Usage Log. A witness must observe the waste and sign attesting to the disposal.

When a controlled substance has been discovered as outdated from either the safe or the box, it must be secured and delivered to the designated agent for disposal. Upon wasting medications, DEA Form 41 is to be completed and filed. Expired medication wasting requires two (2) witness signatures. The actual medication will be disposed of in an approved absorbent material (i.e. Deterra®, or similar commercial product) which does not allow the medication to be reconstituted. The vial/ampule must be discarded in a sharps container.

For controlled substances that have been discovered damaged from either the safe or a box, it must be disposed of in a sharps container after reporting the item to the designated agent. The designated agent will confirm the waste and document the disposal on the DEA Form 106. Immediate notification of Medical Director must be made in the event a DEA Form 106 is needed/used.

Agency Audit

Each agency is required to do a monthly audit on their controlled substances. Monthly audits are to be submitted to the PAEMS Office no later than the last Tuesday of the month. Audits will consist of completion of the Peoria Area EMS Agency Controlled Substance Audit Form, providing copies of PAEMS Controlled Substance Restock and Accountability Forms, PAEMS Controlled Substance Box Location Forms, DEA Form 41 (if applicable), and DEA Form 106 (if applicable).

PAEMS Audit

Each agency that stocks controlled substances will be subject to audits performed by PAEMS personnel. The agency will be contacted at least three (3) business days prior to an audit. An audit will consist of an inventory

of all controlled medications that the agency possesses. This includes medications that are locked in the par level safes as well as any medications that are in service on response vehicles. During the time of the audit all medications will be checked. It is up to the agency to assist the PAEMS personnel in this audit. PAEMS personnel may ask that "in service vehicles" be brought to a specific location or provide access to PAEMS personnel at their designated location i.e. fire station, ambulance station, posting location. A PAEMS audit form will be completed in its entirety and signed by PAEMS personnel and agency designee at the time of the audit. The audit will also include checking of order forms, 222 forms, and DEA forms 41 and 106 (if applicable) and proper, up-to-date, state and federal DEA Licenses. Audit paperwork will be filed at the PAEMS Office once completed. In the event an audit finds any discrepancy, the PAEMS System Medical Director will be notified, as well as the DEA and an immediate investigation will be started.

DEA licenses

The State controlled substance and Federal DEA licenses permit the agency to house controlled substances on site for the purpose of restocking medications. These licenses are specific for the site where controlled substances are housed, and shall be kept with the restock safe. The Medical Director (as the registrant), has full authority over the license. The agency is responsible for all fees associated with obtaining and renewing these licenses, unless the agency is considered "owned" by a governmental authority (federal, state, county, or municipal government), in which case the Federal DEA licensing fee is waived. Should an agency fail to renew the controlled substance license, controlled substances will be relinquished to PAEMS personnel.

EMS agencies are expected to notify Medical Control in the event of a potential or actual "Medical Disaster" A "Medical Disaster" is defined as:

MCI involving 10+ patients

WMD Incident

60+ minute extrication time

"Natural or Man Made Disaster" with multiple transported patients

HAZMAT scene where 1 or more patients are transported to a local hospital

Follow the Communications Policy to notify OSF Medical Control.

The Region 2 Medical Response Team (RMERT) is a deployable 20 bed critical and 100 bed non critical emergency treatment facility. The team consists of doctors, RN's, and Paramedics and may be utilized for any type of medical disaster. Contact OSF Communications at (309)655-5714. In most cases RMERT can be deployed within an hour. If a trend is recognized in numbers and types of patients with similar complaints from a single incident or multiple incidents in a short timeframe the EMS agency shall contact IEMA Illinois Emergency Management Agency Command Center at (800)782-7860 and consult them as to the possibility of a System wide crisis. The Agency shall then contact OSF Medical Control (309)655-6770 and PAEMS System office at (309)655-2113.

DUODOTE Protocol: IDPH requires that each EMS System within the state of Illinois adopt the DuoDote nerve agent protocol for all levels of pre hospital care if the agency carries the medication or if it arrives on scene brought by others. DuoDote kits include two auto-injectors. Atropine-2mg and 2PAM-600mg which are not to be utilized prophylactically but only when S/S of nerve agent exposure. Given similar to Epi auto injector in the lateral aspect of the Quadriceps muscle.

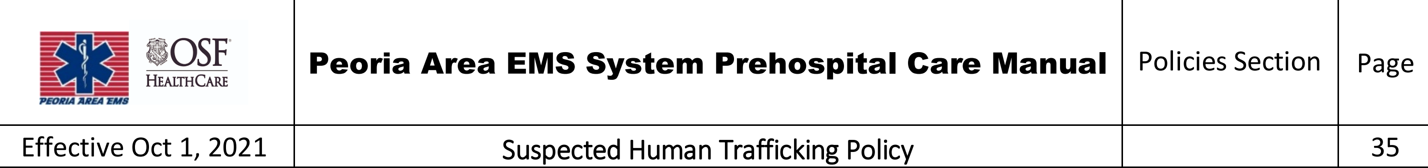
Mild to Moderate Acetylcholinesterase Inhibitor Agent Exposure

Patient (Weight)	Atropine Dose IM or via Auto-injector	Pralidoxime Chloride Dose IM or via 600 mg Auto-injector
Infant: 0-2 years	0.05 mg/kg IM or via auto-injector (*e.g. 0.25 mg and/or 0.5 mg auto-injector*)	15 mg/kg IM
Child: 3-7 yo (13-25 kg)	1 mg IM or via auto-injector (*e.g. one 1 mg auto-injector or two 0.5 mg auto-injectors*)	15 mg/kg IM **OR** One auto-injector (600 mg)
Child: 8-14 yo (26-50 kg)	2 mg IM or via auto-injector (*e.g. one 2 mg auto-injector or two 1 mg auto-injectors)*	15 mg/kg IM **OR** One auto-injector (600 mg)
Adolescent/ Adult	2-4 mg IM or via auto-injector	600 mg IM **OR** One auto-injector (600 mg)
Pregnant Women	2-4 mg IM or via auto-injector	600 mg IM **OR** One auto-injector (600 mg)
Geriatric/ Frail	2 mg IM or via auto-injector	10 mg/kg IM **OR** One auto-injector (600 mg)

Severe exposures require doubling the dosages of both medications through 14yo and the elderly.

Adolescents and Adults shall receive 3 DuoDote kits or 6mg Atropine + 1800mg 2PAM.

Trick to remember Mnemonic
Signs of Organophosphate poisoning:
"DUMBBELLS"
D = Diarrhoea
U = Urination
M = Miosis
B = Bradycardia
B = Bronchorrhea
E = Emnesis
L = Lacrimation
S = Salivation



Human Trafficking: The recruitment, harboring, transportation, provision or obtaining of a person for labor or services through the use of force, fraud, or coercion for the subjection to involuntary servitude, peonage, debt bondage, or slavery.

Identifying victims and reporting suspected cases of Human Trafficking

You may have encountered a victim of human trafficking in the course of your duties. Illinois ranks in the top 10 states for reported HT cases with Central Illinois holding 80% of reported cases. It is important to recognize that HT victims can be any age, race, gender, and nationality including US citizens, and may be found in legitimate and illegitimate labor environments. Many are lured with false promises of well-paying jobs or love, and are forced into domestic servitude, manual labor, other types of forced labor, or commercial sex (prostitution).Traffickers typically prey on vulnerable populations who may have little or no social support network. Economic hardship, social instability, violence, homelessness, and run-a-ways, & displaced due to natural disasters and political instability are common.

There are multiple indicators that a person may be a victim of trafficking listed below are some but not all.

Labor or Service: The person (victim)

Recruited for 1 purpose and forced into some other job. Forced to relinquish their salary to pay off debts. Forced to perform sex acts or is a juvenile engaged in commercial sex. Works long or unusual hours. Inadequately dressed or ill prepared for the work they do.

Control Indicators: The person (victim)

Is not in possession of their own ID or travel documents. Appears to be coached on what to say. Has been threatened or their family threatened by harm. Is passive, timid, or submissive. Has been threatened with deportation or law enforcement actions. Appears confused, afraid, or shows signs of physical/mental abuse. Unable to freely socialize or contact friends or family.

Living Condition Indicators: The person (victim)

Lacks personal possessions or an unstable living environment. Has no freedom of movement or unreasonable security measures like bars on windows and locks on interior doors. Lives in an unsuitable environment and/or deprived of basic needs (food, water, sleep, medical care).

Travel Indicators: The person (Victim)

Does not know their destination or how they got here. Does not know who they are meeting or traveling with someone they do not know or is not their parent or guardian.

Medical Indicators: (The person (Victim)

Has poorly explained scars, injuries, or infections. Has unexplained multiple tattoos (Branding). Is being prevented from revealing their medical history. IS suffering from urinary issues, rectal or sexual organ injuries. Is being treated for chronic/ recurrent back or abdominal pain. Has untreated poor eyesight, dental issues, or hearing problems. Appears malnourished.

Know the signs above. Render the appropriate care for their chief complaint based upon the appropriate protocol(s). The patient should be separated from others during transport. If medical care is refused or not needed and an immediate threat is suspected contact law enforcement. Discretely offer a DCP "Dream Center of Peoria" card.

Contact **Homeland Security Investigation tip-line** (866)347-2423 or online at www.ice.gov/tips.

Contact **National Human Trafficking Resource Ctr** (888)373-7888. This agency is not law enforcement but can help with resources, information, and assistance to help those in need.

These lines are staffed 24/7/365

Other resources: www.dreamcenterpeoria.org, www.a21.org, www.dhs.gov/bluecampaign

Illinois law establishes requirements that any person licensed, certified or otherwise authorized to provide healthcare shall offer immediate and adequate information regarding services available to abuse and neglect victims.

Abuse is defined as physical, mental or sexual injury to (a child or) eligible adult. An eligible domestic partner is defined as a spouse or person who resides in a domestic living situation with another individual suspected of abuse. EMS personnel should not rely on another mandated reporter to file a report on the victim's behalf.

First Responder Care, BLS Care, ILS Care, ALS Care

Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

Reporting Methods

The following telephone numbers regarding services available to victims of abuse shall be offered to all victims of abuse whether they are treated & transported or if they refuse treatment & transport to the hospital:

Elderly Abuse Hotline	**(800)559-7233**
Center for Prevention of Abuse	**(309)691-0551**
Crime Victims Compensation Program	**(800)228-3368**

Rape and sexual assault are acts of violence and may be associated with traumatic injuries, both external and internal. A thorough assessment of the patient's condition should be done and special attention should be given to the patient's mental health needs as well.

Care should be directed at conducting a thorough patient assessment, initiating routine patient care to assure that the patient has a patent airway, is breathing and has a perfusing pulse as well as beginning treatment for shock and preparing the patient for or providing transport.

- Strongly discourage the patient from urinating, washing/showering or changing clothes.
- Collaborate with police to determine what articles (*i.e.* clothing) will be transported with the patient.
- **Do not** physically examine the genital area unless there are obvious injuries that require treatment.
- All linen used by the patient should be left with the patient in the Emergency Department.

2. Transport the patient to a facility with SANE (Sexual Assault Nurse Examiner) nurses and notify law enforcement of patient destination.
3. The following information / telephone numbers regarding services available to victims of abuse shall be offered to all victims of abuse, whether they are treated & transported or if they refuse treatment & transport to the hospital:
    - Center for Prevention of Abuse (309) 691-0551
    - Crime Victims Compensation Program (312) 814-2581

The use of drugs to facilitate a sexual assault is occurring with increasing frequency. These drugs can render a person unconscious or weaken the person to the point that they cannot resist their attacker. Some of the drugs can also cause amnesia and the patient will have no memory of the assault. Date rape drugs have a rapid onset and varying duration of effect. It is important for prehospital personnel to be aware of these agents as well as their effects.

There are certain emergencies that may have a lasting emotional effect on EMS personnel. These include emergencies involving children, co-workers, and familiar or particularly close persons, multiple death situations and disaster incidents. **The Heart of Illinois Critical Incident Stress Management Team** is an important resource in assisting EMS personnel in coping with stressful experiences.

1. EMS providers of the Peoria Area EMS System involved in an unusually stressful incident can contact the Heart of Illinois Critical Incident Stress Management Team.

2. The CISM Team members have specialized training in providing pre-incident education, on-scene support services, defusing, demobilization, formal debriefings, one-on-one debriefings, follow-up services and specialty briefings.

3. Debriefings and stress management services are most effective when conducted within 72 hours of the incident.

4. The CISM Team Coordinator may be reached by contacting Medical Communications at OSF Saint Francis Medical Center at (309) 655-2564.

Incidents involving school buses pose unique challenges to the EMS provider in assuring proper release of uninjured children. Once Medical Control confirms that the minor children are not injured, the custody and responsibility for these children will remain with the responding EMS provider until the children are transferred to parents, legal guardians, school officials or the hospital. If no procedure exists to have children transferred to a parent, legal guardian or school official, then these children will need to be transported to the hospital.

On arrival at the scene, EMS personnel shall determine the category of the incident and request appropriate resources. EMS must also accomplish a complete assessment of the scene to include at least:

- Mechanism of injury
- Number of patients
- Damage to the vehicle
- Triage as outlined in the System Plan

Once this has been accomplished, then the patients may be assigned to one of the following categories:

CATEGORY A: Significant mechanism of injury (*i.e.* rollover, high-speed impact, intrusion into the bus, etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have significant injuries or significant injury is present in one or more children. *All children in this category must be transferred to an appropriate hospital unless a Peoria Area EMS System refusal form is signed by a parent or legal guardian*.

CATEGORY B: Suspicious mechanism of injury (*i.e.* speed of impact, some intrusion into the bus, etc.) – school bus occupancy indicates that at least one child may reasonably be expected to have minor injuries or minor injury in one or more children exists with no obvious mechanism of injury that could reasonably be expected to cause significant injuries. *EMS personnel must complete the EMS Multiple Casualty Release Form and secure a signature of an appropriate school official*.

CATEGORY C: No obvious mechanism of injury – school bus occupancy indicates no injuries may be present and that the release of uninjured children may be the only EMS need. No injuries are found to be present in any of the children. *EMS personnel must complete the EMS Multiple Casualty Release Form and secure a signature of an appropriate school official*.

CATEGORY D: If the pediatric patient(s) have **special healthcare needs** and/or communication difficulties, then all of these patients must be transported to the hospital for evaluation unless approval for release is received from Medical Control or a parent/legal guardian has signed the approved refusal form.

1. After determining the category of the incident, EMS personnel shall determine the extent of EMS involvement and **contact Medical Control**.
2. Adults, victims 18 years and older, and occupants of other vehicles will be treated or released in accordance with routine System operating procedures.
3. If Medical Control has approved usage of this policy/plan, then each provider will implement their procedure for contacting parents, legal guardians or appropriate school officials to receive custody of uninjured children.
4. The approved system *Multiple Casualty Release Form* for school bus incidents must be utilized for all children who will not be transported.

5. Each child transported must have a completed run report.
6. One run report indicating the nature of the incident, etc. shall be completed and must include all information regarding the incident including the number of patients released. Keep a copy of this report with the release form or with refusal forms signed by the parents.
7. A parent, legal guardian or appropriate school official must be given a copy of the refusal/release form.
8. Any parent or legal guardian who arrives on scene to remove and assume responsibility for their child must sign an individual refusal form.
9. EMS providers shall use reasonable means to contact the parents or school officials. Once the identity and authority of the parent, legal guardian or school official has been established, the EMS provider may release the child to that individual or alternate transport source. School officials will follow their established program for informing parents or legal guardians regarding the incident.
10. The health and safety of the child is the primary concern. It is the responsibility of the EMS provider to assure that the child is returned to the parent or placed on the school's alternate transport vehicle. If the EMS provider on scene determines a child should receive a physician evaluation or be offered medical care, the child **will be transported** to the hospital unless a parent or legal guardian is on scene and consents to refusal.
11. Each prehospital provider agency in the Peoria Area EMS System who may likely respond to a school bus incident must contact the school superintendents in their district to obtain the name and title of the "appropriate school official" who may take responsibility for the child on the bus involved in the incident.
12. Copies of documentation must be forwarded to the EMS Office (Quality Assurance Coordinator) for review within 24 hours of utilization of this policy.

Early identification of cardiac infarction is crucial. The benefits of PCI are time-dependent and the 12-Lead EKG may provide early recognition of acute myocardial infarction (AMI).

Indications for a 12-Lead EKG include (but are not limited to):

- Chest pain / discomfort
- Epigastric pain
- Shortness of breath
- Syncope (or near-syncope)
- Pulmonary edema / Cardiogenic shock
- Wide complex tachycardia
- Symptomatic bradycardia
- Stroke
- Altered level of consciousness (ALOC)
- Vague "unwell" symptoms in diabetic and elderly patients.

Upon determining that a patient has a complaint or symptoms that indicate performing a 12-Lead:

1. Initiate *Routine ALS Care* and **obtain 12-Lead EKG as soon as possible**.
2. Transmit the EKG via **TWIAGE** or Zoll monitor and **contact the receiving hospital** as soon as possible.
3. **Contact Medical Control** for consultation/orders when needed.
4. Upon arrival at the emergency department, a copy of the 12-Lead EKG should be given to the accepting nurse with request for physician review as soon as possible.
5. Copies of the 12-Lead EKG must be included with the patient care record.

Critical Thinking Elements

- Communicate ST elevation MI (STEMI) early in the report to the receiving hospital or Medical Control. (STEMI Alert).
- Communicate acute stroke / suspected stroke early in the report to the receiving hospital or Medical Control (Stroke Alert).